Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement of $946.18 for dates of service, 08/22/01 and 08/29/01.

   b. The request was received on 02/13/02

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   Based on Commission Rule 133.307 (g) (4) , the Division notified the Requestor with a copy to the insurance carrier Austin Representative of the Requestor's requirement to submit two copies of additional documentation relevant to the fee dispute on 05/28/02. There is no response from the Requestor in the file. There is no Carrier initial response nor a 14 day response in the file. The "No Response Submitted" from the Carrier sheet is reflected in Exhibit II of the Commission's case file. A "No Additional Information Received" from the Requestor is reflected in Exhibit I.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 02/13/02
   "This letter is a request for Dispute Resolution pertaining to reimbursement for services rendered to the above named claimant. Our contention is: The treatment received was medically necessary, pre-authorization was received, and billing was done in accordance with TWCC fee guidelines. Therefore, payment should be made in accordance with said guideline…."

2. Respondent: No position statement

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are, 08/22/01 and 08/29/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
08/22/01	99070	$11.50	$0.00	G	DOP for all dates	MFG General Instructions (IV); MGR (I) SGR (V); CPT Descriptor	The carrier has denied the charges in dispute as "G INCLUDED IN GLOBAL CHARGE; M REDUCED TO FAIR AND REASONABLE". The Medical Review Division's decision is rendered based on denial codes submitted to the Provider prior to the date of this dispute being filed. There is no medical documentation in the file to support that services were rendered. N**o** reimbursement is recommended
08/22/01	A4209	$57.60	$0.00	G			
08/22/01	A4649	$106.00	$0.00	G			
08/22/01	99499 RR	$800.00	$75.00	M			
08/22/01	A4215	$11.52	$0.00	G			
08/22/01	A4208	$11.52	$0.00	G			
08/29/01	A4215	$11.52	$0.00	G			
08/29/01	A4208	$11.52	$0.00	G			
Totals		$1021.18	$75.00				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 7th day of August 2002.

Denise Terry, R.N.
Medical Dispute Resolution Officer
Medical Review Division

DT/dt

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.